TESTIMONY

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Before the Public Health Committee

Raised HB 5386 AN ACT CONCNERING CARE COORDINATION FOR CHRONIC DISEASE

Senator Gerratana, Representative Johnson and honorable members of the Public Health Committee. My name is Barbara Katz, Director of Clinical Program Development for VNA Community Healthcare (VNACHC). I am an RN with more than 40 years of experience in community health, medical practice and home health care. My agency, VNA Community Healthcare, services 36 towns and approximately 4000 patients per year.

Any state initiative to prevent and control chronic illness should maximize efficiency utilizing existing community resources. Medicare Certified home health care agencies, particularly nonprofits, are such a resource. Below is a list of specific home health care agency programs and capabilities that could be utilized by the CT Dept of Public Health in its chronic disease initiatives.

Screenings for chronic disease and injury risk factors - Certified home health care agencies conduct screenings for high blood pressure, diabetes, obesity and falls at health fairs and community sites. Using screening results, community nurses help people get medical attention and make lifestyle changes before chronic disease or complications occur. Through a grant from the Connecticut Collaboration to Prevent Falls, VNACHC has screened over 500 local residents and counseled them on fall risk reduction Follow up screenings indicate that the vast majority have remained fall free or have had fewer falls .

Health coaching - VNA Community Healthcare, through a grant from the Anthem Blue Cross and Blue Shield Foundation screened and coached over 400 family members of people with heart disease to significantly lower their blood pressure, undertake exercise programs, stop smoking, eat healthier and lower their cholesterol and blood lipids. VNACHC, like many nonprofit home health care agencies, provides more than a dozen Well Right Now Nurse Health Coaching Clinics in senior housing sites and other community settings.

Medical consumerism education – VNACHC helps community residents become better consumers of health care through a booklet and seminar called *How to be Your Own Health Care Advocate*. Through a grant from the Connecticut Foundation for Better Health, VNACHC and a collaborative of local organizations, including a health department, are launching a health literacy campaign called *Put Yourself in Charge* that uses video models and simple written tools to help patients give and get vital health information at medical visits. VNACHC was recently selected as a partner for the *Choosing Wisely* program of the American Board of Internal Medicine and Consumer Reports. VNACHC will utilize the program's health decision support tools in community education classes, publications, web site and social media.

Chronic disease education and support – Medicare Certified home health care agencies reduce hospital readmissions by teaching patients to self manage Diabetes, Congestive Heart Failure and Chronic Obstructive Lung Disease using simple, pictorial health education materials and effective patient education methods. In addition, home health care clinicians help patients develop systems to organize medication taking, home exercise, medical transportation, diet changes, self monitoring and reporting. VNACHC also sponsors programs such as Tai Chi to Prevent Falls, Parkinson's Exercise Program, Smoking Cessation and many other wellness education classes.

Patient engagement and self-management support initiatives – VNACHC and other home health care agencies train and certify clinicians in Integrated Chronic Care, an evidence based approach to health literacy, patient goal setting, effective patient education and fostering adherence to medical treatment plans. VNACHC has built patient engagement best practices into its daily clinical work. In addition, the agency teaches all clinicians Motivational Interviewing, a communication technique that helps patients find their own motivation to change health behaviors.

Family caregiver education and support – VNA Community Healthcare provides caregiver counseling, education and support groups. Under a grant from the National Family Caregiver Alliance caregivers of patients with cardiac disease are receiving health coaching on reducing stress and maintaining their own health.

Care coordination – Home health care agency liaison nurses visit patients in hospitals and skilled nursing facilities prior to discharge. The liaison nurse helps transition patients in the smoothest and safest way possible through patient education about what to expect at home and identifying obstacles to home self management. Home health care staff assess how the patient and family function at home and coordinate with the primary care physician to develop the best possible plan of care.

Home based technology for monitoring and self management support – Home care agencies use home telemonitoring machines to help patients weigh themselves, take their blood pressure and check their blood oxygen. These readings help patients learn how their behavior affects their body. It also allows the home health care agency to closely monitor very ill chronic disease patients and take action sooner. In addition, we use tools such as automatic medication dispensers and medical alert devices to help people adhere to medical treatment and get immediate help when needed.

In summary, it may be tempting for the state health infrastructure to start a chronic disease initiative from scratch. The initiative will be both more effective and less costly if existing programs from certified home care agencies, such as the ones described, are incorporated into a new statewide program.

Please contact me with further questions or assistance (bkatz@vna-commh.org) or 203-458-4232.

Thank you.